California CABG Outcomes Reporting Program (CCORP)
EXTENSION REQUEST FORM

To: Office of Statewide Health Planning and Development (OSHPD)
Healthcare Quality and Analysis Division (HQAD)
Fax Number: 916-322-9718

Date: _____

1. Hospital Name: _____
2. Hospital Facility Identification Number: _____
3. Report Period Begin Date: _____
4. Report Period End Date: _____
5. **Justification for extension request** (Include the actions taken by the hospital to produce the report by the due date, those factors that prevent completion of the report by the due date, and the actions and the time (days) needed to accommodate those factors):

_____

_____

_____

_____

_____

6. Number of Days of Extension Request: _____
7. Person Submitting Extension Request (print): _____
8. Signature: _____
9. Fax Return Number: _____

OSHPD USE ONLY

Extension Request: Granted Denied
By:
Date:

REVISED DUE DATE:
Formal notification of extension request grant/denial will be provided via certified mail.